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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JONATHON W. SHIVELEY a.k.a. ROBERT MOSE FREYTA** 1130 Arcadia Avenue #E Arcadia, CA 91007 **Registered Nurse License No. 514247** Respondent.	Case No. 2010 - 166 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 11, 1995, the Board of Registered Nursing issued Registered Nurse License Number 514247 to Jonathon W. Shiveley a.k.a. Robert Mose Freyta (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2010, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section

references are to the Business and Professions Code unless otherwise indicated.

4. Section 2761 of the Code provides in part that "The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

5. Title 16, California Administrative Code of Regulations, (hereafter "CCR"), section 1442, provides:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

6. Title 16, CCR section 1443, provides:

"Incompetence means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

7. Title 16, "CCR", section 1444, provides in pertinent part:

"A conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. Such convictions or acts shall include but not be limited to the following:

..."(c) Theft, dishonesty, fraud, or deceit.

8. Section 2762 of the Code provides, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this

chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

..."(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

FIRST CAUSE FOR DISCIPLINE

(Incompetence and/or Gross Ne*gligence)*

9. In 2002, Respondent was employed by the Los Angeles Sheriff's Department at the Men's Central Jail (MCJ).

On or about February 2, 2002, he was on night shift duty in the 8000 module of the facility which houses from one hundred to two hundred inmates having certain medical afflictions, one of which is diabetes. Two of the inmates are named J.J.

One is diabetic, requiring a daily injection of insulin and the other is non-diabetic, requiring two injections of Lovenox daily for his treatment of Thrombosis.

On February 6, 2002, respondent Shively and another RN, Oscar Casino, were working together on the same shift at the facility's 8000 Module. Each was responsible for distributing medications to inmates. Those tasks were divided according to the initial letters of the inmates' surnames. Casino had the letters from A through L and respondent Shively served the others from M through Z. At about 3:30 p.m., Sheriff's Deputy Berg called the inmates from their cells and had them positioned alphabetically against the wall. Those with surname initials from A through L stood on one side and those from M to Z on the opposite wall. The usual procedure was for the RN's to ask each inmate for his name and booking number, and then verify that information with the wristband he wears.

The medication chart shows the name of the drug and the time for dispensing for each inmate. Proper nursing practice requires each RN to draw the medication for each of his assigned patients and to deliver it directly himself. Injection of a drug drawn by another RN is prohibited. On the date in reference, there were several medications that were not dispensed for various reasons on the 4:00 p.m. schedule and were left on the medication cart after the others had been delivered. One of these was meant for the diabetic J.J., but he was not there to receive it because he was in court at the time. The 8:00 p.m. medication schedule called for a Lovenox injection for the non-diabetic Jackson.

After arriving at the inmate's cell, Casino was informed, (according to his Internal Affairs Bureau (IAB) interview) and supported by Berg's testimony, that another RN had already given him one injection at 4:00 p.m. that afternoon, which apparently had been intended for the diabetic inmate. There were only two RNs on duty that shift, Casino and respondent Shively.

The diabetic inmate identified respondent Shively through a photographic array, as the RN who gave him the injection at approximately 4:00 p.m. He stated in an IAB interview, corroborated by Berg's testimony, that the Respondent did not look at his (inmate's) wristband, or verify his name and booking number. He said that Casino did so before injecting Lovenox at 8:00 p.m. Soon thereafter, while Casino and respondent were in the nurses'station, Casino asked Respondent if he had given the non-diabetic J.J. an injection, and that he answered affirmatively, and he added that it was a dose of insulin. He also requested Casino not tell anyone about the incident.

Although the non-diabetic inmate stated that he had been injected at approximately 4:00 p.m., his chart showed no record of it for that time. In his interview with IAB investigators, Casino said that Respondent had admitted giving the insulin injection and he (Casino) did not report it because he believed that Respondent was going to do so. During his first IAB interview, Respondent denied that he had erroneously given an insulin injection to the non-diabetic J.J. and also denied being approached by Casino about administering such an injection. In his testimony at his Administrative Civil Service Hearing (Civil Service Hearing), he denied all the charges contained in the letter of charges.

In his second IAB interview, Respondent was asked if he had ever observed an RN administer an injection drawn by another RN, and he answered in the affirmative. He was then asked if he had done so, specifically on February 6, 2002 or at any other time. His response to each of those questions was" "I don't recall."

Los Angeles County's Medical Services Policy No. 349 required that an incident report be submitted to the Shift Supervisor as soon as possible after discovery of a medication error. Neither Respondent nor Casino had done so for this incident. It was not until three days later that the error became known when the inmate complained to the Charge Nurse that he had been given the wrong injection three days earlier.

10. The following "Findings of Fact" resulted from the Respondent's Civil Service Hearing.

1. Respondent had been employed as a Registered Nurse in the Sheriff's Department for approximately three and one-half years.
2. He had no previous disciplinary history and his performance evaluations were satisfactory.
3. During the night shift on February 6, 2002, he erroneously injected insulin into a non-diabetic inmate.
4. He failed to report the incident to his superior as required by standard procedures and solicited Nurse Casino to withhold that information.
5. His response to Internal Affairs investigators regarding the matter were in consistent and evasive.
6. No evidence was presented to show that a Skelly violation had occurred.

11. The following "Conclusions of Law" resulted from the Respondent's Civil Service Hearing.

1. The allegations contained in the Los Angeles County letter of July 30, 2003 are true.
2. There was no Skelly violation.
3. The disciplinary penalty imposed is appropriate.

12. The Hearing Officer's recommendation to the Board of Civil Commissions was that

the following order be approved and adopted:

In the matter of the fifteen (15) day suspension of Robert Freyta from the position of Staff Nurse, Sheriff's Department, effective July 30, 2003, Los Angeles County is sustained.

SECOND CAUSE FOR DISCIPLINE

(Dishonesty, Fraud or Deceit)

12. The matters alleged in paragraph 9 are incorporated by reference.

13. Respondent's actions as alleged in paragraph 9 constitute dishonesty, fraud, and or deceit within the meaning of title 16, CCR, §1444.

THIRD CAUSE FOR DISCIPLINE

(Theft, Dishonesty, Fraud or Deceit)

14. On or about September 28, 2007, Respondent was employed at San Gabriel Medical Center in San Gabriel, California and was assigned to the Sub-Acute Unit.

At 0700 hours on September 28, 2007, the Morphine Sulfate for TCU medication cart one was counted at 30. Respondent was observed interacting with TCU medication cart one at approximately 0730 hours. After Respondent was observed interacting with TCU medication cart one, staff checked the cart and noted that the morphine count had been changed to ten (10) on the narcotic sheet, and the number of vials of morphine was ten (10).

At the nursing station, staff confirmed in conversation that the 0700 count had been 30 vials morphine. Respondent made no comment. A staff member confronted Respondent, saying "I saw you in the medication cart, what did you do?" Respondent replied, "let's go fix it." Respondent went to the cart and returned the missing 20 vials of morphine and changed the number of vials back to 30 on the narcotic sheet, noting it was per the instruction of another staff member.

Respondent requested that the incident not be reported to the Director of Nursing, because it would be reported to the state and would ruin his career. When confronted by the Director of Nursing at 1420 hours, Respondent stated that he had no comment and resigned at the time.

15. Respondent's actions alleged in paragraph 12 constitute theft, dishonesty, fraud or deceit within the meaning of title 16, CCR §1444.

FOURTH CAUSE FOR DISCIPLINE

(Incompetence, Or Gross Negligence)

16. The matters alleged in paragraph 12 are incorporated by reference.

17. Respondent's actions alleged in paragraph 12 constitute incompetence and/or gross negligence within the meaning of section 2761(a)(1) of the code.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 514247, issued to Jonathon W. Shiveley a.k.a. Robert Mose Freyta Jonathon W. Shiveley aka Robert Mose Freyta.

2. Ordering Jonathon W. Shiveley aka Robert Mose Freyta to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 9/10/09

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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